

## COMMISSION ON ENHANCING AGENCY OUTCOMES SUMMARY SHEET

### Control Long-Term Care Costs

#### Background on Long-Term Care

Long-term care (LTC) refers to both institutional and community-based care for persons who need assistance due to a physical, cognitive, or mental disability or condition. The goal of LTC is to allow a person to attain and maintain the highest level of functioning and independent living reasonably possible. Medicaid is the primary payor of long-term care nationally and in Connecticut (other sources include Medicare, private insurance, out-of-pocket pay by individuals, and other public sources).<sup>1</sup>

Because nursing home beds were available, a higher percentage of Connecticut's elderly population is receiving nursing home than the national average – 5.5% of 65+ in Connecticut compared to 3.7% of the elderly nationally. What this also means is that in Connecticut a less frail population is served in nursing homes than is the case nationally. The most common measure used to determine level of care needed is the ability to accomplish activities of daily living (ADLs), like dressing, bathing, and feeding.<sup>2</sup> The lower the score, the less assistance needed. In Connecticut, the average ADL score was 3.7 while the national average was 4.0.; only two states had a lower score, and only four other states had a 3.7 ADL average score.

Long-term care Medicaid expenditures are expected to more than double by 2025 if no action is taken.<sup>3</sup> Currently, Connecticut long-term care Medicaid expenditures are:

- 13 percent of the overall state budget;
- 49 percent of the entire DSS budget; and
- 53 percent of the state's Medicaid budget.

Perhaps one of the major reasons that Connecticut spends so much of its Medicaid long-term care dollars on nursing facilities is that when this was the only type of care for which Medicaid would reimburse a state, Connecticut responded by having an ample supply of nursing homes and beds for its residents. While a moratorium on new nursing homes has been in effect since 1991, Connecticut still has many more nursing home beds for its elderly population (65+) than the national average. In 2008, Connecticut had 1 bed for every 16.5 people 65 and over, while the national average was 1 nursing home bed for every 22 people 65 and over.<sup>4</sup>

Based on surveys for Connecticut's long-term care needs assessment, almost 80 percent of CT's residents would like to continue living in their homes with home health or homemaker services

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<sup>1</sup> Medicaid can only be accessed after individuals have spent their savings and become impoverished.

<sup>2</sup> Average ADL Dependence – Based on data obtained from CMS OSCAR Nursing Facility database as of December 2008. Average ADL dependence is defined as the sum of residents that are somewhat or fully dependent on staff for the five ADLs (i.e., dressing, bathing, transferring, toileting, and eating) divided by the total number of residents.

<sup>3</sup> CT Commission on Aging presentation to the Commission on Enhancing Agency Outcomes, August 11, 2010.

<sup>4</sup> The State Long-Term Health Care Sector, Characteristics, Utilization, and Government Funding: 2009 Update (calculations by CEAO staff).

provided at home.<sup>5</sup> It is also about two to three times less expensive to live in the community as opposed to living in institutional care. In FY 06, for example, the average cost for institutional care in CT was \$74,637 and the average cost for home and community based care was \$32,902.<sup>6</sup> Traditionally, however, Medicaid has made institutional care<sup>7</sup> easier to access than home and community-based care. Medicaid has historically only paid for long-term care in institutional settings and a waiver has been required to obtain reimbursement for long-term care in the community.

In Connecticut, approximately 35 percent of long-term care Medicaid dollars are spent on home and community based-services (HCBS), ranking Connecticut 34<sup>th</sup> in HCBS spending in FY 07. Connecticut continued to spend 35 percent (\$873.9 million) of its Medicaid long-term care expenditures (\$2.4 billion) on Medicaid HCBS in FY 09. (In September 2010, the CEAO sent a letter to Governor Rell requesting that she more aggressively make long-term care and its costs a priority.) There are several strategies under consideration to control long-term health care costs.

### Re-Balancing Strategy

Currently, at least six states spend more than half of their long-term care dollars on alternatives to nursing facilities, including Alaska, California, Minnesota, New Mexico, Oregon and Washington State (Colorado, Idaho, North Carolina, Texas and Vermont are moving in the same direction).<sup>8</sup>

On March 23, 2010, the federal *Patient Protection and Affordable Care Act* (PPACA) became law. The PPACA contains financial incentives for states currently spending less than 50 percent of their Medicaid long-term care dollars on health and community based services, to spend at least 50 percent of their long-term care dollars on non-institutional services, **by offering a grant for each individual who leaves a nursing home to receive services in the community.** Referred to as the “State Balancing Incentive Payment Program,” it runs from October 1, 2011 through September 30, 2015, and offers temporary financial incentives to states that in FY 09 had spent less than 50 percent of their Medicaid long-term care dollars on HCBS to increase its spending in that area. Participating states spending between 25-50 percent will receive a two percent increase in their federal matching funds for HCBS services; states spending less than 25 percent will receive a five percent increase in HCBS reimbursement. In FY 09, Connecticut spent 35 percent on Medicaid HCBS.<sup>9</sup>

A condition of the increased match is that, within six months of applying, states must implement administrative changes designed to increase Medicaid HCBS utilization including:

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<sup>5</sup> CT Commission on Aging presentation to the Commission on Enhancing Agency Outcomes, August 11, 2010

<sup>6</sup> University of Connecticut Health Center’s Center on Aging, *Long Term Care Needs Assessment Legislative Briefing—Follow-up to Questions Asked*, January 16, 2008.

<sup>7</sup> Institutional care includes nursing homes, intermediate care facilities for people with developmental disabilities, psychiatric hospitals, and chronic disease hospitals (Source: CT Long-Term Care Planning Committee Long-Term Care Plan, January 2010)

<sup>8</sup> *Tennessee’s Bold Leap in Care for the Aged and Disabled*, by Christine Vestal, Stateline.org, October 12, 2010

<sup>9</sup> Backgrounder: Federal Health Care Reform: Long-Term Care Provisions, OLR Research Report (2010-R-0304), September 10, 2010

1. “No wrong door single point of entry system” enabling consumers to access long-term care information, referrals, and financial and functional eligibility assessments through a single access point;
2. “conflict free” case management to develop individual service plans and arrange for and conduct ongoing service monitoring; and
3. core standardized assessment tools used statewide to determine eligibility and services.

Participating states are expected to increase their Medicaid HCBS spending to a target percentage by September 30, 2015. States whose Medicaid HCBS spending was less than 25 percent in 2009 must increase it to 25 percent. All other states must increase such spending to 50 percent.

The CT Long Term Care Planning Committee recommends increasing the ratio of home and community-based and institutional care to 75 percent HCBS by 2025. This would occur through a one percent increase in the percentage of persons in Medicaid long-term care in the community each year. Thus, from 2010 to 2015, there would be an increase from 53 percent to 58 percent of long-term care provided in the community.

However, in order for Connecticut to take full advantage of PPACA, the rebalancing would have to occur at a quicker rate, reaching 67 percent by 2015 (see figure below).

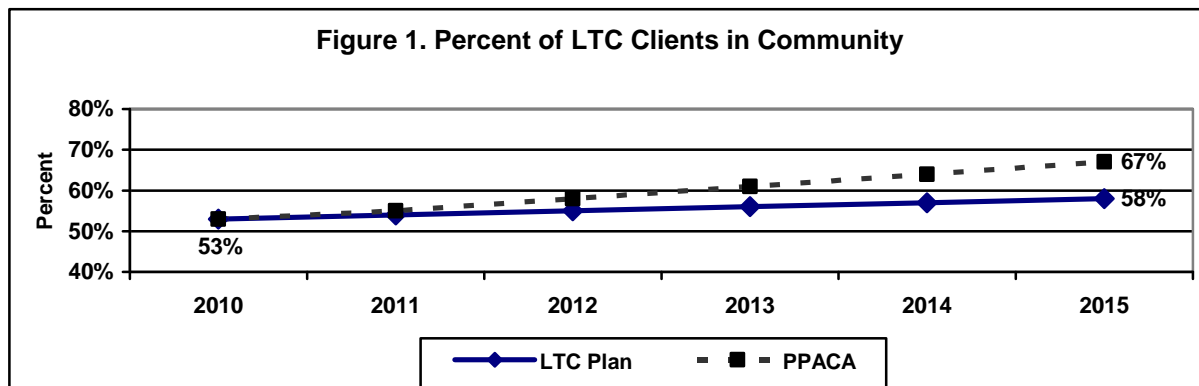


Table 1 shows the potential difference in savings by rebalancing at a faster rate.

Savings	2011	2012	2013	2014	2015	Total
No Rebalance	\$0	\$0	\$0	\$0	\$0	\$0
LTC Plan Rebalance	\$16.6	\$34.2	\$51.9	\$69.6	\$87.2	\$259.5
PPACA Rebalance	\$34.2	\$87.2	\$140.1	\$193	\$246	\$700.5

Assumes no change in the overall number of LTC clients (N=40,097), and annual cost of HCBS is \$43,999 less than annual cost of Institutional Care.

The figures in Table 1 do not include the value of the increased federal match for HCBS care under the PPACA. At the increased percentage level (52% vs. 50%), and based on currently HCBS spending of \$874 million, the increased federal reimbursement would be \$17.5 million.

## **Money Follows the Person Program**

Another strategy to control long-term health care costs is the Money Follows the Person (MFP) program, a recent Connecticut initiative designed to promote personal independence and achieve fiscal efficiencies. MFP is a five-year federal demonstration program that helps states move people from institutional care such as nursing homes, into less restrictive, community-based settings. (As indicated previously, the population being served in Connecticut's nursing homes is less frail than the national average, so the target population for this program is there). MFP increases the federal Medicaid match up to 75 percent for the first year that program participants are living in community-based settings.

Connecticut estimated the actual cost of care for persons in the MFP program to be \$3,676 per month, with a net cost to Connecticut (after the \$2,713 federal match) of \$963 per match. This compares favorably with the cost of institutional care, which is estimated to be \$6,658 per month, with a net cost to Connecticut (after the \$4,008 federal match) of \$2,651.<sup>10</sup>

CT DSS began implementing MFP in December 2008 and has a target of moving 700 people into the community. The legislature also directed DSS to plan for a program to extend MFP services to adults who do not meet the federal six-month institutionalization requirement (PA 08-180). However, implementation of this directive was subsequently postponed until 2012 (PA 09-5, September 2009 Special Session).

PPACA also extends the federal Money Follows the Person demonstration program until 2016 and decreases the institutional residency requirement by half (from six months to 90 days).

## **Single Waiver Strategy**

There are a number of Medicaid waivers operating in Connecticut to permit Medicaid payment for other than institutional care, each managed and implemented separately, and created for individuals with very specific types of disabilities. Waivers include:<sup>11,12</sup>

- Home Care Program for Elders (DSS Medicaid waiver for individuals age 65 and over who would otherwise be in nursing homes)
- Personal Care Assistance (DSS Medicaid waiver for individuals age 16-64 with physical disabilities, who would otherwise require institutionalization)
- Acquired Brain Injury (DSS Medicaid waiver for individuals age 18-64 with brain injuries)
- Katie Beckett Waiver (DSS Medicaid waiver primarily for children with severe physical disabilities, who would otherwise require institutionalization)
- Comprehensive Supports (DSS Medicaid waiver for persons age 18 and over with developmental disabilities living in group homes, organized day programs, or living in their own homes, who would otherwise require institutionalization)

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<sup>10</sup> Source of data: CT DSS, Money Follows the Person Rebalancing Demonstration Legislative Status Update, October 2009.

<sup>11</sup> CT Commission on Aging, "Break Down the Silos" chart, 12/9/09

<sup>12</sup> More information on the waivers is found in the CEAO Summary Sheet on Section 1115 Medicaid Waiver for SAGA

- Individuals with Serious Mental Illness (DMHAS Medicaid waiver for persons age 18-64 currently in nursing facilities or at risk for this level of care, that allow participants to live in the community and avoid institutional care)

There are at least 31 states that have gone to using a single Medicaid 1915(c) waiver to provide home and community-based services to both their elderly as well as their disabled, young adult population, including Maine, Rhode Island, New Hampshire, New York and New Jersey.<sup>13</sup> In its September 2, 2010 letter to Governor Rell, the Commission on Enhancing Agency Outcomes encouraged simplification and streamlining of federal waivers and related programs and pilots.

### **Consolidation and Integration of CT's Long-Term Care Functions**

Connecticut provides publicly-financed long-term care services and supports to older adults and persons with disabilities through a somewhat fractured governance structure consisting of a vast array of departments and programs that often operate in silos serving narrowly-defined segments of the population.<sup>14</sup>

There are many state agencies that must coordinate long-term care, with the four major agencies responsible for aspects of long-term care being:

- Department of Social Services
- Department of Developmental Services
- Department of Mental Health and Addiction Services
- Department of Public Health

Consolidation and integration of Connecticut's long-term care functions has been recommended by the Connecticut Regional Institute for the 21<sup>st</sup> Century, and the CT Long Term Care Planning Committee. The potential proposal to consolidate back office functions for these state agencies will help promote the consolidation and integration of these long-term care functions as interaction across agencies is increased. The single waiver strategy as well as a single point of entry may also help to consolidate and integrate Connecticut's long-term care functions.

### **Single Point of Entry**

The Connecticut Regional Institute for the 21<sup>st</sup> Century recommended that Connecticut create a statewide single-point of entry for long-term care information and referral across all ages and disabilities. This change would address the difficulties reported by CT residents who need long-term care to obtain basic information about available services. Additionally, a single point of entry would satisfy the PPACA requirement of "No wrong door single point of entry system." Further, the September 2, 2010 letter to Governor Rell from the Commission on Enhancing Agency Outcomes considered creation of a workable statewide single point of entry that is customer-friendly to be a key first step in Connecticut's long-term care reform.

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<sup>13</sup> OLR Research Report (2008-R-0122) States with Single Medicaid Waivers for Home and Community-Based Services, February 27, 2008.

<sup>14</sup> CT Long-Term Care Planning Committee Long-Term Care Plan, January 2010

## Caveats

Control of long-term health care costs is a complex issue and, with any of the strategies proposed, there are several caveats that bear mentioning.

Woodwork effect. There is concern that offering more home-based services will lead to people who had not previously considered entering a nursing home to “come out of the woodwork” and apply for Medicaid. There have been surveys that show that for each patient in a nursing facility, there are two more with similar disabilities making do at home.<sup>15</sup> One potential strategy to prepare for such an effect would be to start opening up community-based services by phasing in certain age groups. For example, individuals age 90 and above might be the initial group offered HCBS.

Assistance to nursing homes. Nursing homes are already struggling financial institutions, and are likely to oppose rebalancing efforts that reallocate resources from their facilities to community services. A key strategy outlined in the September 2, 2010 CEAO letter to Governor Rell was to assist nursing homes in diversifying their business models. The number of nursing home beds has declined by about 2,230 since FY 01. However, in comparison to the national ratio of 1 nursing home bed for every 22 elderly people (1:22)—Connecticut’s ratio is 1:16.5. Connecticut still has about 7,000 more nursing home beds than is the norm. Recognizing that bed surplus, policymakers must take a hard line in granting rate relief to financially troubled homes<sup>16</sup> or in helping homes out of bankruptcy, when it might be better to relocate residents to other homes or the community. In Minnesota, grants are offered for nursing homes to voluntarily “turn-in” or close beds. According to a recent report, Minnesota is now closing approximately 1,000 beds a year.<sup>17</sup> The same report indicates that in Vermont, the reimbursement model is changing in some areas of the state, projecting bed demand and then issuing an RFP to select the facilities with which it would contract for the needed bed days.

Whatever method is used, it seems clear that enhancing a community-based long-term care system without reducing the number of nursing home beds and facilities will not save money, but indeed might prompt a parallel, very expensive system. Therefore, any plan that is developed should set a goal of funding the national ratio of nursing home bed (1:22 elderly) by 2017, and closing 7,000 nursing home beds by that date (closure rate similar to Minnesota).

Champion of long-term care. Because the long-term care system is complicated, with multiple types and levels of care needs, diverse funding, competing long-term care providers with significant investments, and a structure that needs to meet personal choice and court-mandated policy goals, there is a need for someone from the governor’s administration to be responsible and accountable for quickly developing a strategy to implement a plan for Connecticut’s long-term care.

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<sup>15</sup> *Tennessee’s Bold Leap in Care for the Aged and Disabled*, by Christine Vestal, Stateline.org, October 12, 2010

<sup>16</sup> In FY 08 16 facilities requested \$11.2 million, and received \$4.6 million, and in FY 09, 27 facilities requested \$19.8 million and received \$7.9 million. Another 15 facilities had pending requests for \$6.7 million in FY 10. DSS presentation 2009.

<sup>17</sup> Topics in Rebalancing the State of Long-Term Care Systems, Kane, Priester, and Kane. A CMS-funded project, May 2008.

## Summary

With long-term care Medicaid expenditures expected to more than double by 2025 if no action is taken, an **aggressive re-balancing strategy** is needed to increase the proportion of long-term care provided in homes and communities rather than in institutions. Beyond helping to control long-term health care costs, it is the preference of many of CT's residents to continue living in their own homes with assistance. Use of a **single Medicaid 1915(c) waiver** to provide home and community based services to both the elderly as well as the disabled, young adult population, would facilitate re-balancing, as would a **single point of entry** for long-term care information and referral, and **consolidation and integration of long-term care functions** spread across multiple agencies. Further, a plan must be developed that avoids establishing a parallel long-term care system, which will mean a **reduction of nursing home beds**.

To achieve this, the new administration should quickly designate a **champion of long-term care** who would provide responsibility and accountability for implementing a plan for Connecticut's long-term care. As shown in Table 1, potential savings in a single year could be as much as **\$16-\$34 million**.

## **Appendix A**